April 28, 2026

Honorable Michael Rodrigues
Chair, Senate Ways and Means
Honorable Joanne Comerford
Vice Chair, Senate Ways and Means
Massachusetts Legislature
State House
Boston, MA 02133

Dear Chair Rodrigues, Vice Chair Comerford, and members of the Senate Ways and Means Committee:

Re: Opposition to S.2973 (formerly S.1115), An Act to provide continuum of care for severe mental illness

We are organizations that advocate for the rights of people with disabilities and organizations that advocate for people who have or who are perceived to have mental health conditions. We write in opposition to S.2973, An Act to provide continuum of care for severe mental illness, which would establish in Massachusetts a system of involuntary outpatient commitment (IOC) for people with psychiatric diagnoses.

Research demonstrates that access to a comprehensive array of well-funded community mental health services can prevent crisis, minimize negative outcomes, and promote recovery for people with mental health conditions. Unfortunately, IOC relies on force and coercion, too often undermining opportunities for meaningful engagement with people with mental health conditions.

We oppose this bill because it

- ***doesn't improve mental health outcomes,***
- ***promotes racial disparities in our mental health system, and***
- ***doesn't advance the autonomy and dignity of people with disabilities.***

This bill would potentially pull thousands of people into the court system and force them to submit to treatment or face evaluation for psychiatric hospitalization

S.2973 would create a process whereby courts could order individuals with mental health conditions living in the community to participate in treatment interventions they do not want.

A judge could compel an adult to accept "critical community mental health services," an undefined term which most often includes the involuntary administration of antipsychotic medication. A judge could consider an involuntary treatment plan upon finding that the person has "severe mental illness" and is "gravely disabled" – another vague term that could apply to anyone a mental health provider believes is not taking adequate care of themselves. The judge could order such a plan for a person with a mental illness who had been involuntarily hospitalized or incarcerated twice in the past three years OR a person who had made one or more acts of serious violent behavior or threats of, or attempts at, serious physical harm. The other criteria for an order – services would prevent serious harm to the individual or others, likelihood of benefit, and lack of voluntary participation in outpatient services – are subjective and broad.

This bill would potentially affect thousands of people, not just those who under current law are incompetent to make treatment decisions. And, the court-ordered plan could include not only compliance with medication, but also requirements regarding mental health supervision, employment, food, clothing, and shelter. Once an involuntary treatment plan is in place, if a judge finds the person non-compliant with treatment, they could order an evaluation of whether failure to hospitalize would create a likelihood of serious harm. This action would potentially result in involuntary hospitalization.

We have serious concerns with introducing IOC in Massachusetts

IOC does not improve mental health outcomes

Studies do not show that IOC improves mental health outcomes, results in more people receiving more care, or reduces homelessness. Multiple studies do show that whatever benefits may come from IOC laws derive not from its coercive nature, but from the expansion of services and supports that are sometimes established in conjunction with the law.

IOC results in racial disparities in implementation

IOC reinforces and aggravates existing disparities in our service system, effectively establishing a separate mental health system in BIPOC communities. Research on New

York's IOC law (commonly referred to as "Kendra's Law") shows significant racial disparities in its implementation. A 2009 study found that courts were, on average, five times as likely to impose outpatient commitment on African American people than on white people.[1]

Disparities have continued in New York to this day. A recent paper reported that there were 3,674 individuals subject to outpatient commitment orders in New York State as of February 25, 2025. Of those people, 38% were Black, although Black people constitute on 17.7% of the state's population. Likewise, 26% of those subject to orders were Hispanic (19.8% of the population). White people represent 54% of New York's population, but only 31% of the persons under Kendra's law orders.[2]

Additionally, IOC is particularly problematic for BIPOC communities because members of those communities are already overrepresented in mandated psychiatric services, jails, and prisons. BIPOC community members are more often treated as inpatients and are four times more likely to be legally mandated to treatment than their White counterparts.[3] There is also a greater likelihood that the police are involved in the hospital admissions of BIPOC community members for psychiatric care than for other community members.

> Involuntary outpatient commitment threatens the autonomy, dignity, and liberty of people with disabilities

People who live with mental health and substance use conditions and with disabilities widely oppose outpatient commitment as it threatens autonomy, dignity, and liberty, and is not consistent with fundamental precepts of disability rights and recovery movements.

We support effective, voluntary approaches to engage people with mental health conditions

Our organizations recommend investment in proven, voluntary services for people with mental health conditions including:

- Community based behavioral-health programs, with walk-in support and extended hours, culturally and linguistically responsive interventions, and access to crisis services, urgent care, and longer-term supports.

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[1] Jeffrey Swanson et al., Racial Disparities In Involuntary Outpatient Commitment: Are They Real?, 28 Health Affairs 816 (May/June 2009), https://sci-hub.se/10.1377/hlthaff.28.3.816.

[2] New York Lawyers in the Public Interest, Implementation of Kendra's Law Continues to be Severely Biased (2025), available at https://www.nylpi.org/wp-content/uploads/2025/03/Implementation-ofKendras-Law-Continues-to-be-Severely-Biased-Report-1.pdf.

[3] Patricia A. Galon et al., Influence of Race on Outpatient Commitment and Assertive Community Treatment for Persons with Severe and Persistent Mental Illness, 26 SCIENCE DIRECT 202, 204 (June 2012)

- Non-clinical options, including peer respites, peer supports embedded in more traditional services, peer-led Recovery Learning Communities, Living Room programs, and peer recovery coaches (for people with substance use conditions).
- Supportive housing, combining access to permanent, safe housing with voluntary services and supports -- which has a proven track record of success and savings. Some supportive housing models are designed to serve hard-to-reach individuals who are chronically unhoused and often have disabling mental health and substance use conditions.

For all these reasons, we strongly oppose the IOC bill pending in the Massachusetts Legislature.

Thank you for your consideration.

Sincerely,

Alliance for Rights and Recovery

American Association of People with Disabilities

Autistic People of Color Fund

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Bazelon Center for Mental Health Law

Disability Rights Education and Defense Fund

International Society for Psychological and Social Approaches to Psychosis, U.S. Chapter

Law Project for Psychiatric Rights (aka Psychrights)

MindFreedom International

National Coalition for Mental Health Recovery

Psychiatric Rehabilitation Association